STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

[Managed Care Organization]

AMENDMENT NO. 8 TO THE
CONTRACT FOR FURNISHING HEALTH SERVICES
BY A MANAGED CARE ORGANIZATION
2018-24-XXX-KA8

WHEREAS, the Parties to the Contract for Furnishing Health Services by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **[Managed Care Organization]** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 5.18 is amended by deleting and replacing subsection 5.18.6 with the following:

5.18.6 **Community Transition Initiative**
Effective January 1, 2020, Contractor shall implement an initiative specific to achieving transitions from institutional settings to the community for Enrollees who have continuously resided in a Nursing Facility or a Specialized Mental Health Rehabilitation Facility for a minimum of ninety (90) days. Contractor shall prioritize community transitions for class members of the Williams v. Quinn and Colbert v. Quinn consent decrees. The initiative shall be in effect for each calendar year through 2021.

2. Article V is amended by adding new section 5.41 and its subsections:

5.41 Handling of Sensitive Data

5.41.1 Pursuant to Executive Order 2019-08, the Department will provide Contractor on at least a monthly basis with highly sensitive data from the Illinois Department of Public Health (DPH) related to certain of Contractor's Enrollees who have data in the DPH's HIV/AIDS Registry. Contractor shall handle such data in the strictest confidence in compliance with the privacy provisions of all applicable laws, rules, and regulations, including HIPAA, the AIDS Confidentiality Act (410 ILCS 305), the HIV/Aids Registry Act (410 ILCS 310), and the Illinois Sexually Transmissible Disease Control Act (410 ILCS 325), and with the provisions of this section 5.41. The purpose of the data exchange is to advance the goals of zero community

transmissions of HIV and ensuring that persons living with HIV will get the care they need to thrive.

5.41.2 The details of the HIV-related data received from the DPH via the Department shall be closely held and accessible only to Contractor's Chief Medical Officer (CMO) and their designees, all of whom will be subject to the same standards and liability as the CMO. The data shall only be integrated into a repository for the sole purpose of Care Coordination and treatment of Enrollees living with HIV. Contractor's repository for the data shall have data security protocols, consistent with those outlined in Attachment XIV, in place which shall be submitted to the Department for review and approval.

5.41.3 Contractor's CMO shall use the data received from the HIV/AIDS Registry, along with Contractor's pharmacy, medical, and other claims data, to provide alerts to Care Coordinators to prompt them to ensure all best practices regarding the management and treatment of HIV are being followed with respect to Enrollees, including periodic viral load testing, drug regimen prescribing and adherence, and annual physician visits. These alerts may be developed based on the data permitted to be shared under this Contract and may include viral suppression status ("suppressed" or "not suppressed"), the date of the last lab test, and name of the Provider that ordered the last lab test (if available). Contractor shall work with appropriate HIV consumer and legal advocacy groups for the target population to develop and implement best practices for outreach and engagement.

5.41.4 Contractor shall track, and report quality metrics related to HIV, including the CQMC HIV Consensus Core Set, as directed by the Department.

3. Article VII is amended by adding new section 7.25 and its subsections:

7.25 CY2021 RISK CORRIDOR

The Department shall utilize for calendar year 2021, for all Enrollees, a risk corridor mechanism that allows Contractor to operate with the understanding that if there are excessive losses or profits as a result of the COVID-19 public health emergency's impact on utilization of Covered Services, the mechanism ensures that Contractor will share the risk of such deviations to a certain degree with the Department.

7.25.1 For the purpose of this risk corridor calculation, benefit expenses include Covered Services and approved in-lieu-of services, as well as non-Covered Services and Provider-based care coordination services approved by the Department as part of Contractor's reinvestment proposal to address needs resulting from the COVID-19 public health emergency. Benefit expenses exclude healthcare quality improvement expenses as defined in 42 CFR 438.8(e)(2). Benefit expenses include incurred but not yet paid expenses, as reported by Contractor within a timeframe and format provided by the Department.

7.25.2 The risk corridor settlement will be calculated for Contractor across all HealthChoice Illinois populations and rating regions combined. The risk corridor ratio is calculated as actual benefit expenses divided by the target benefit expense amount for Contractor.

7.25.3 In the event Contractor's risk corridor ratio is greater than 103%, the Department shall reimburse Contractor the target amount multiplied by:

7.25.3.1 50.0% multiplied by [risk corridor ratio less 103.0%], if the risk corridor ratio is less than or equal to 105.0%; or

7.25.3.2 1.0% plus [risk corridor ratio less 105.0%], if the risk corridor ratio exceeds 105.0%.

7.25.4 In the event Contractor's risk corridor ratio is less than 97.0%, the Department shall make a recoupment from Contractor of the target amount multiplied by:

7.25.4.1 50.0% multiplied by [97.0% less risk corridor ratio], if the risk corridor ratio is greater than or equal to 95.0%; or

7.25.4.2 1.0% plus [95.0% less risk corridor ratio], if the risk corridor is less than 95.0%.

7.25.5 The risk corridor will be calculated using values reported consistent with the medical loss ratio (MLR) reporting. The payment or recoupment amount will be an adjustment to the denominator of the MLR for the calculation of the calendar year 2021 MLR.

4. Article VII is further amended by adding new section 7.26 as follows:

7.26 REIMBURSEMENT FOR EMERGENCY GROUND AMBULANCE SERVICE

For dates of service on or after January 1, 2020 and continuing through March 31, 2021, Contractor shall reimburse for emergency ground ambulance services (current procedural terminology (CPT) codes A0427 and A0429), including affiliated mileage and oxygen, at the FFS Medicaid Program fee schedule rates as provided by the Department, inclusive of Government Emergency Medical Transportation (GEMT) rates. These services are outside of Contractor's risk-based Capitation payments and shall be paid on behalf of the Department by Contractor as an Administrative Services Organization. The Department shall reimburse Contractor on a quarterly basis the actual paid amounts expended by Contractor based on encounter claims accepted by the Department during the quarter, or, other quarterly documentation mutually agreed to by the Parties, plus a $35,000 per quarter administrative fee. Accrued payments are due to Contractor thirty (30) days after execution of this Contract amendment; subsequent payments are due within thirty (30) days of the end of a quarter. State Prompt Payment Act (30 ILCS 540) requirements apply to these payments.

5. Section 9.1 is amended by adding new subsection 9.1.41 as follows:

9.1.41 **Loss of legal authority.** Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which federal CMS has withdrawn federal authority, or which is the subject of legislative repeal) Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust payment of Capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If

Contractor works on a program or activity no longer authorized after the date the legal authority for the work ends, Contractor will not be paid for that work. If the Department paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if Contractor worked on a program or activity prior to the date the legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6. Attachment XI: Healthcare and Quality of Life Performance Measures is amended by adding the following measures to Table 1:

Acronym	Performance measure	Further description	Reporting methodology	Source
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of ED visits for which enrollees 13 years and older with a principal diagnosis of alcohol or other drug abuse or dependence received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days). (Effective for measure year 2020, reporting year 2021)	Admin	HEDIS
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	Percentage of visits or discharges for which enrollees 13 years and older received follow-up for substance use disorder within the 30 days after the visit or discharge and within the 7 days after the visit or discharge. (Effective for measure year 2020, reporting year 2021)	Admin	HEDIS
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Percentage of ED visits for which enrollees 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days). (Effective for measure year 2020, reporting year 2021)	Admin	HEDIS
POD	Pharmacotherapy for Opioid Use Disorder	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among enrollees age 16 and older with a diagnosis of OUD. (Effective for measure year 2020, reporting year 2021)	Admin	HEDIS

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 8 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

[MANAGED CARE ORGANIZATION]	DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title: Director_____
Date:_____	Date:_____
FEIN:_____	